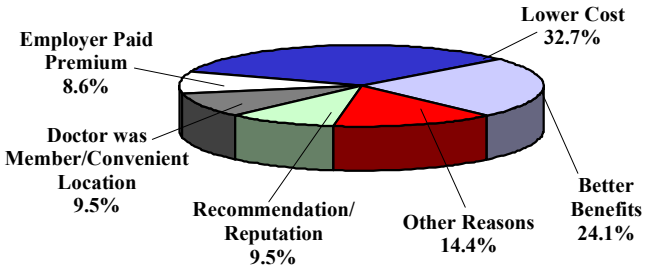
Theme 2: Improving Managed Care Payment and Delivery

The Balanced Budget Act of 1997 created the Medicare+Choice (M+C) program, expanding beneficiary choices to include a broader range of coordinated care plans such as health maintenance organizations (HMOs), preferred provider organizations, provider-sponsored organizations, medical savings accounts, and private fee-for-service plans. Since 1997, CMS has been working to ensure a wide range of high-quality health care options for Medicare beneficiaries. As part of this effort, we continue to devote significant time and effort to better understanding the M+C program's successes and shortcomings. For example, we are developing systems for measuring beneficiary risk to refine capitated payments, and conducting demonstrations that test and evaluate the effectiveness of a wide range of capitated health plan arrangements to increase the choices available to Medicare beneficiaries. CMS research and demonstration projects include Medicare capitation demonstrations, Medicare capitation models that integrate acute and long-term care services, an examination of trends in HMO enrollment, and other aspects of M+C plan. In addition, we are examining programs to increase access and quality of health care for Medicaid beneficiaries and limit rising costs through the increased use of managed care.

Lower Costs or Better Benefits Were The Most Common Reason for Joining a Medicare Risk HMO



Source: *CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.*

98-234 Decisionmaking in Managed Care Organizations

Project Officer: Brigid Goody
Period: July 1998-August 2002
Awardee: Health Economics Research
Funding: $257,749

Description: This task order examines a broad range of managed care decision-making strategies, their implications for the development and diffusion of new technologies and their impact on future health care costs, especially Medicare program costs. The project had three phases. First, case studies of managed-care organizations focused on components of plan decision-making related to the scope of insurance coverage: benefits offered, premium and coinsurance structure, and coverage of specific technologies. Second, it examined how the research and development decisions of private firms are affected by increased managed care penetration. Third, it developed a conceptual framework for simulating the long term growth in health care expenditures, especially Medicare program costs, which incorporates the interaction between increased managed care penetration and the research and development process.

Status: A final report presenting findings from the interviews with managed care organizations, contracting hospitals and research and development companies has been received. They found that, while managed care plans attempt to control use of certain technologies, their ability to do so is more restricted than expected. Similarly, managed care undoubtedly influences manufacturer research-and-development investment decisions through coverage and payment policies. It is, however, not clear that it has changed the likelihood that cost-increasing technologies will come to market, nor has it altered the fundamental feedback relationship among insurance, technological innovation, and health care expenditure growth. ■

00-110 Next Generation Medicare Managed Care Payment System

Project Officer: Sarah Thomas
Period: September 2000-April 2002
Awardee: Urban Institute
Funding: $635,897

Description: This project assesses a possible "next generation" payment methodology (currently called the "Direct Model") for the Medicare+Choice (M+C) program, that blends county rates with a national rate, or national pricing. This study is preparing a conceptual paper that describes and makes possible one potential approach to managed care payments without a fee-for-service (FFS) based county ratebook. Two possible steps could be taken to separate Medicare managed care payments from their traditional FFS basis. The first could be considered an interim approach, and would address the problem of basing managed care payment on FFS practice patterns. In a second, longer term approach CMS could move to what could be called a "direct" payment model. Under this direct model, managed care payments would move away (all or in part) from their current county FFS basis. In this direct payment approach, risk adjustment models could be calibrated using either a combination of FFS and managed care encounter data, or managed care data alone. This risk-based estimated expenditure would be multiplied by a geographic price index to adjust for local price differences.

Status: Work is underway on the completion of the direct model concept paper. These concepts are not possible to implement today, when actual costs for managed care services are all but unknown, and most national health-specific price indexes are considered weak. This model presumes that the risk-adjuster method would account sufficiently for practice pattern variability. In addition, this change would require agreement on the extent of parity between Medicare's expenditures for beneficiaries enrolled in FFS versus managed care. ■

96-010 **Medicare Coordinated Open Enrollment**

Project Officer: Ronald Deacon
Period: September 1996-September 2001
Awardee: Benova
Funding: $2,959,970

Description: This project supported the Medicare Competitive Pricing Demonstration initiative. Activities included: 1) meeting with beneficiary advocacy groups, managed care plans, and other local organizations; 2) preparing analysis of site-specific features to assist in final planning; 3) adapting prototype beneficiary information materials to the specific features of the intended demonstration sites; and 4) assisting CMS with beneficiary education and outreach activities.

Status: The project assisted with demonstration developmental activities in Kansas City and Phoenix, which were the two sites designated for the demonstration. Legislation prohibited any additional activities in the two sites in fiscal years 2000 and 2001. ■

95-017 **Medicare Competitive Pricing Demonstrations**

Project Officer: Ronald Deacon
Period: September 1995-September 2001
Awardee: Abt Associates
Funding: $3,258,000

Description: The project supported the design, development, and implementation of Medicare Competitive Pricing Demonstrations. In these demonstrations, CMS replaces the existing fee-for-service-based health maintenance organization (HMO) payment system with a market-based pricing system. All competing Medicare HMOs in designated metropolitan statistical areas are asked to bid a capitation price that is required to provide a pre-defined benefit package. CMS arrays the bids, selects a payment level, and pays all HMOs this government contribution. Payments are adjusted to reflect enrollee risk characteristics.

Status: Several option papers were prepared for decisions on demonstration design and site selection. A Competitive Pricing Advisory Committee (CPAC) met several times and selected a demonstration design and sites for the demonstration using the information supplied. Several option papers were also prepared for two local Area Advisory Committees in Kansas City and Phoenix. The project will continue to develop required informational papers for the CPAC and will assist the CPAC to prepare a report to Congress mandated by the Balanced Budget Refinement Act of 1999. For further information e-mail compete@cms.hhs.gov. ■

99-036 **Evaluation of the Competitive Pricing Demonstration—Phase I**

Project Officer: Brigid Goody
Period: June 1999-August 2001
Awardee: Health Economics Research
Funding: $458,288

Description: The purpose of this phase of the evaluation of the Competitive Pricing Demonstration is to provide CMS with timely feedback on the implementation and operational experience of each demonstration site. A case study methodology will be used to develop both qualitative and quantitative information required to assess the strengths and weaknesses of the demonstration.

Status: The contractor has completed a case study of the advisory committee process. Since the implementation of the demonstration has been delayed until January 2002, further evaluation activities are being delayed. ■

98-236 **Department of Defense Subvention Demonstration Evaluation**

Project Officer: Victor McVicker
Period: September 1998-March 2002
Awardee: RAND Corporation
Funding: $1,411,439

Description: Under the demonstration, enrollment in the Department of Defense's (DoD) Senior Prime plan is offered to military retirees over age 65 who live within 40 miles of the primary care facilities of one of the six sites, have recently used military health facility services, and are enrolled in Medicare Part B. The Senior Prime plans must meet all relevant requirements for Medicare+Choice plans. Medicare makes a capitation payment to DoD for each enrollee, and DoD must maintain a level of effort for health care services to all retirees who are also Medicare beneficiaries, whether or not they choose to enroll, that is based on fiscal year 1996 DoD experience. The evaluation seeks to answer the basic question: can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to military-Medicare-eligible beneficiaries? The evaluation will seek the answer by examining issues in four basic areas: 1) enrollment demand; 2) enrollee benefits; 3) cost of the program; and 4) impacts on other DoD and Medicare beneficiaries.

Status: Reports are available from the National Technical Information Service (NTIS): accession numbers PB99 149056 and PB99 162505. In addition, General Accounting Office (GAO) Reports are available on the GAO Web site (http://www.gao.gov): GAO/HEHS 99-39 and GGD-99-161. ■

98-266 **Medicare Choices Demonstration: USD Senior Health Plan**

Project Officer: Pamela Kelly
Period: March 1998-February 2001
Awardee: University of California at San Diego, Healthcare Network
Funding: $0

Description: The Medicare Choices Demonstration tested the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and evaluates the suitability of such options for the Medicare program. The ultimate goal was to provide Medicare beneficiaries with more delivery system choices and to provide CMS with alternative payment arrangements.

Status: The demonstration ended December 2000; however, the waiver continued for another two months. ■

98-269 **Medicare Choices Demonstration: Medicare Smart**

Project Officer: Cynthia Mason
Period: April 1998-March 2001
Awardee: St. Joseph's Health System
Funding: $0

Description: The Medicare Choices Demonstration tested the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and evaluated the suitability of such options for the Medicare program. The ultimate goal was to provide Medicare beneficiaries with more delivery system choices and to provide CMS with alternative payment arrangements.

Status: The project terminated in December 1999; however, the waivers were continued through the following March. The Medicare Choices demonstration gave CMS a head start on developing solutions to a wide range of implementation issues (such as risk sharing, payment methods, certification requirements, and quality monitoring systems) that would be associated with some of the legislative expansions of Medicare managed care under consideration. ■

97-030 **Medicare Choices Demonstration: Verification of Encounter Data**

Project Officer: Victor McVicker
Period: September 1997-September 2002
Awardee: MEDSTAT Group
Funding: $2,640,401

Description: This project ensures that accurate and comprehensive encounter data are reported in the Medicare Choices Demonstration. It assesses the health plan information systems' capabilities, the overall reasonableness of the encounter data against benchmarks, and the validity of the encounter data against medical record information. On a quarterly basis and for each of the plans participating in the demonstration, a sample of enrollees is selected and medical records are examined to determine whether the information in the encounters (pseudo-claims) reflects what is in the medical record. Using the medical record, the project assesses the timeliness of the encounter data, the validity of the codes in the encounter data, and the completeness of the information.

Status: The data are being finalized to make the risk adjusted payments. The Medicare Choices Demonstration plans have had considerable difficulty supplying encounter data that is in the correct format and contains all the required information to the FIs and carriers. As a result, most of Medstat's efforts have been directed at providing technical assistance to the plans rather than performing the medical record reviews as originally planned. ■

98-237 **Evaluation of the Medical Savings Account Demonstration**

Project Officer: Renee Mentnech
Period: September 1998-September 2003
Awardee: Barents Group
Funding: $6,546,119

Description: This project evaluates the Medical Savings Account (MSA) Demonstration. It compares the experience of MSA enrollees with other Medicare beneficiaries. The contractor will also act as a coordinator between CMS and the demonstration participants, including beneficiaries and health plans, in order to ensure that accurate, reliable, and complete data are collected.

Status: To date, no insurers have elected to participate in the MSA Demonstration. In light of this development, a report is being prepared on the reasons for this lack of interest. ■

90-023 **United Mine Workers of America Demonstration**

Project Officer: Lee Phipps
Period: July 1990-June 2001
Awardee: United Mine Workers of America Health and Retirement Funds
Funding: $0

Description: The United Mine Workers of America (UMWA) Health and Retirement Funds (the Funds) is a waiver-only demonstration that provides a risk-based Part B capitated payment and some limited Part A coverage for the Funds' Medicare-eligible retirees and dependents. The Funds has established Part B managed care networks in selected areas of Alabama, Pennsylvania, and West Virginia. CMS has continued the current Part B capitation approach and has implemented risk-sharing for Part A in these three areas. However, for fiscal year 1999-2000, the entire UMWA Funds beneficiaries, nationally, will be included along with the three areas noted above for risk-sharing program. The new waivers also allow for

direct admission to nursing homes for Funds beneficiaries. The Funds is expected to encourage preventive care among its population and to substitute less expensive care for Part A whenever appropriate.

Status: The new waivers were awarded, and the project has been ongoing since January 1997. A 1-year extension was requested and awarded effective July 1, 2000 to June 30, 2001. This extension was given in order to review a new proposal submitted by the United Mine Workers. ■

99-029 **Selection Bias in Medicare Health Maintenance Organizations (HMO) at Enrollment and Disenrollment**

Project Officer: Gerald Riley
Period: May 1999-June 2001
Awardee: University of Minnesota
Funding: $170,882

Description: This project consists of several analyses. Selectivity-corrected mortality analyses identified the effect of health maintenance organization (HMO) membership on mortality, rather than interpreting mortality as a health status indicator. It also examined the relationship of pre-enrollment and post-disenrollment health care expenditures and the association of multiple prior year inpatient hospital expenditures on the probability of joining an HMO. The project determined how HMO enrollment and disenrollment are related to social economic status characteristics. Of particular interest was the high disenrollment rate of African Americans from Medicare HMOs. The study also determined whether the amount of time in Medicare managed care is a good predictor of utilization in the first year after switching back to fee-for-service Medicare.

Status: Several draft papers are being revised to incorporate CMS comments. It is anticipated final versions will be available in early 2002. ■

99-040 **Study of Cost-based Plans**

Project Officer: Tom Hutchinson
Period: August 1999-February 2001
Awardee: Barents Group
Funding: $243,647

Description: This project was an analysis of cost-based plans including the geographic distribution of plans and the availability of existing or potential Medicare+Choice (M+C) organizations in these areas and the feasibility of these cost-based plans converting to M+C organizations. Also included was an examination of payments made to these plans and a comparison of what would have been paid under an M+C contract, and an estimation of the impact on Medicare beneficiaries if the cost-based plans are discontinued as an election under Medicare.

Status: This project provided technical and logistical support to CMS in the preparation of a report to Congress on the impact on beneficiaries of discontinuing the Medicare cost-based plans. ■

99-079 **Research on Plan Performance Indicators**

Project Officer: Vivian Braxton
Period: September 1999-September 2001
Awardee: Barents Group
Funding: $773,965

Description: This project provided background and support activities to identify key areas for additional research and development of improved performance measures for health plans. In addition to the focus on improved performance measures, the project also focused on developing strategies to increase the potential for purchasers and consumers to use these measures effectively. The project included background literature reviews and site visits to selected employers and other purchasers to assess their needs for and uses of current performance measures.

Status: CMS sponsored, as part of this project, a two-day conference on The Future of Plan Performance Measurement in May 2000. Nineteen research papers were presented at this conference with breakout sessions centered on identifying key topic areas for measuring and improving plan performance. Subsequent to the conference, a number of the research papers were published in a Supplement to the *Health Care Financing Review* (spring 2001). The project is complete. ■

00-025 **Study and Report to Congress on Reporting of Encounter Data**

Project Officer: Jane Andrews
Period: April 2000-January 2001
Awardee: Kathpal Technologies
Funding: $224,424

Description: This was a study of the costs and burdens of compliance with reporting requirements for encounter data that are necessary for comprehensive risk adjustment. The Balanced Budget Refinement Act of 1999 (BBRA) required a study on how to reduce the costs and burdens on Medicare+Choice organizations (M+COs) in complying with reporting requirements for encounter data needed in establishing and implementing a risk adjustment methodology used in making payments. The Balanced Budget Act of 1997 (BBA) mandated that payments to M+COs must account for variation in per capita costs based on health status. In order to implement this mandate, the BBA provided the authority to collect hospital encounter data for admissions occurring after July 1997. It also allowed us to require the submission of other encounter data (for example, hospital outpatient and physician). CMS selected the principal inpatient diagnostic cost group (PIP-DCG) model, based on inpatient hospital data. M+COs, who are responsible for the data submission, began submitting inpatient hospital encounter data in July 1998. CMS will continue to use the PIP-DCG model through 2003. In 2004, CMS will move to a comprehensive model which incorporates encounter data from additional sites of care. M+COs will begin submitting physician data in October 2000 and hospital outpatient encounter data in January 2001, retroactive to October 2000.

Status: Encounter data will be used to determine risk adjusted rates under a comprehensive model in 2004. Most M+COs have 2 years experience in collecting and submitting inpatient data. As CMS moves toward a comprehensive risk adjustment model over the course of the next four years, Congress has requested a study on how to reduce the costs and burdens associated with encounter data collection and submission needed to support the comprehensive model. It delivered the draft of a report that can serve as the basis for a Report to Congress. ■

00-054 **Development of Test Plans, Test Protocols, and Data Analysis Tools—Abbreviated UB92; Availability of Pricing Data**

Project Officer: Edward Lain
Period: September 2000-December 2001
Awardee: Jing Xing Health and Safety Resources
Funding: $124,500

Description: This project looked at ways to obtain pricing information for Medicare managed care comparable to the fee-for-service program. The goal was to pay Medicare managed care organizations (MMCOs) based on better estimates of health care costs of the population they enroll. Using encounter data will assist in addressing biased selection in Medicare managed care. The two major data elements necessary for this effort were the diagnosis and the adjudicated price of the service(s). In order to get the diagnostic data quickly and with no burden on the MMCOs, a new electronic format was introduced at the outset of the encounter data collection process called the abbreviated UB92. This abbreviated format however, does not gather charge or pricing information from the hospital.

Status: Testing of various default values is ongoing. ■

00-111 **Survey of Medicare Beneficiaries Who Were Involuntarily Disenrolled from HMOs that Withdrew from Medicare or Reduced their Service Areas**

Project Officer: Gerald Riley
Period: September 2000-October 2002
Awardee: University of Wisconsin - Madison/Center for Health Systems Research and Analysis
Funding: $551,823

Description: This project involves development and implementation of a survey that asks about the experience of beneficiaries whose plans withdrew from Medicare or reduced their service areas in January 2001. In January 2001, over 100 health maintenance organizations (HMOs) withdrew from the Medicare

program or reduced their service areas. Over 900,000 Medicare beneficiaries were disenrolled involuntarily, and had to enroll in another HMO or go to fee-for-service (FFS). Many of these disenrollees did not have another managed care plan available to them. These beneficiaries had no choice but to go to FFS, and replacing the benefits through Medigap insurance is usually very expensive, and may be unaffordable for some. Joining another HMO or going to FFS may also force many beneficiaries to change doctors, creating dissatisfaction and disrupting existing patterns of care.

Status: The purpose of the survey was to determine how Medicare beneficiaries were affected by the withdrawal or service area reduction of their plans. The survey specifically addressed the type of new insurance arrangements beneficiaries made; what their informational needs were; disruptions to patterns of care; changes in benefits; changes in out-of-pocket costs; psychological impacts; and differences among subgroups of beneficiaries. Approximately 3,400 beneficiaries responded to the mail survey with telephone follow-up. Analyses indicated that most beneficiaries found the information they received about the withdrawals to be adequate, but there were clear information and understanding gaps among beneficiaries regarding the options available to them and the implications of plans withdrawing from Medicare. ■

96-083 End Stage Renal Disease (ESRD) Managed Care Demonstration: Health Options

Project Officer: Bonnie Edington
Period: September 1996-December 2002
Awardee: Advanced Renal Options
Funding: $0

Description: The original demonstration program tested whether open enrollment of end stage renal disease (ESRD) patients in managed care was feasible with a capitation rate adjusted for age, treatment status, and cause of renal failure, and additional payment made for extra benefits.

Status: As of October 2000, when open enrollment concluded, there were 700 ESRD beneficiaries enrolled, approximately 11 percent of the ESRD population in the service area. Data collection for evaluation purposes ended May 31, 2001, at the conclusion of the mandated 3-year period, and the evaluation report is due May 2002. Waivers were renewed for the period June 1, 2001, through December 31, 2002 for residual demonstration enrollees to continue to receive the extra benefits, with CMS paying an unadjusted capitation rate based on the demonstration rate. ■

96-084 ESRD Managed Care Demonstration: Kaiser Foundation Health Plan-Southern California

Project Officer: Bonnie Edington
Period: September 1996-January 2001
Awardee: Kaiser Foundation Health Plan
Funding: $175,000

Description: Under this end stage renal disease (ESRD) demonstration, rates are paid on the basis of treatment status (maintenance dialysis, transplant episode, or functioning graft), and adjusted for patient age and whether diabetes was the cause of kidney failure. Demonstration rates are based on 100 percent of fee for service, and additional non-Medicare-covered benefits are to be provided. The demonstration tests whether: 1) year-round open enrollment of Medicare's ESRD patients in managed care is feasible; 2) integrated acute- and chronic-care services and case management for ESRD patients improves health outcomes; 3) capitation rates reflecting patients' treatment needs increases the probability of kidney transplant; and (4) additional benefits are cost-effective.

Status: As of November 1, 2000, when open enrollment ended, there were 1,333 ESRD beneficiaries enrolled in the Kaiser demonstration, about 11 percent of the service area. The demonstration at this site concluded January 2001. ■

97-022 End Stage Renal Disease (ESRD) Capitation Demonstration, Evaluation

Project Officer: Joel Greer
Period: August 1997-May 2002
Awardee: Lewin-VHI
Funding: $2,442,533

Description: The project uses survey, claims, and medical records data to evaluate the efficacy and cost-effectiveness of permitting Medicare beneficiaries with end stage renal disease (ESRD) to enroll in managed care.

Status: Preliminary analyses are complete. ■

SOCIAL HEALTH MAINTENANCE ORGANIZATION PROJECT FOR LONG-TERM CARE

These projects were developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until after the S/HMO Transition Report to Congress is submitted. The Benefits Improvement and Protection Act of 2000 further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003.

84-004 **Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc.**

Project Officer: Thomas Theis
Period: August 1984-August 2003
Awardee: Elderplan, Inc.
Funding: $0

Description: Elderplan is one of the long-term care provider sites that developed and added an acute-care service component.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan uses both Medicare and Medicaid waivers. ■

84-006 **Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research**

Project Officer: Thomas Theis
Period: August 1984-August 2003
Awardee: Kaiser Permanente Center for Health Research
Funding: $0

Description: Kaiser Permanente Center for Health Research (doing business as Senior Advantage II) is one of the health maintenance organization sites that developed and added a long-term care component to its service package.

Status: Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II used Medicare waivers only. ■

84-007 **Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan**

Project Officer: Thomas Theis
Period: August 1984-August 2003
Awardee: SCAN Health Plan
Funding: $0

Description: SCAN Health Plan is one of the long-term care provider sites that developed and added an acute-care service component.

Status: SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. ■

SECOND GENERATION SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION

The purpose of the second-generation social health maintenance organization (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term-care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The S/HMO-II model provides an opportunity to test models of care focusing on geriatrics.

95-088 Second Generation Social Health Maintenance Organization Demonstration: Nevada

Project Officer: Thomas Theis
Period: November 1996-August 2003
Awardee: Health Plan of Nevada, Inc.
Funding: $0

Description: The Health Plan of Nevada is one of six organizations originally selected to participate in the project.

Status: The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. Health Plan of Nevada (HPN) is the only operational site in the demonstration. HPN began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 2001 was over 38,000 members. ■

98-271 Second Generation Social Health Maintenance Organization Demonstration: Florida

Project Officer: James Hawthorne
Period: May 1998-June 2002
Awardee: Florida, Department of Elder Affairs
Funding: $150,000

Description: This project funds the Florida State Department of Elder Affairs purchase of technical assistance, and planning activities for a second generation social health maintenance organization (S/HMO). The goal of this project is to study the feasibility of implementing a Second Generation S/HMO in Florida and, should this prove feasible, to develop the specifications needed for the State to issue a Request for Proposal.

Status: A second 12-month no-cost extension has been approved extending the period of performance to June 30, 2002. ■

99-131 Second Generation Social Health Maintenance Organization Demonstration: Maryland

Project Officer: James Hawthorne
Period: April 1999-June 2001
Awardee: State of Maryland, Department of Health and Mental Hygiene
Funding: $109,211

Description: This cooperative agreement provides the Maryland State Department of Health and Mental Hygiene with funds to purchase technical assistance and to support planning activities for a second generation social health maintenance organization (HMO). The goal of this project is to study the feasibility of implementing a Second Generation Social HMO in Maryland and, should this prove feasible, to develop the specifications needed for the State to issue a Request for Proposal.

Status: This project received a second no-cost extension and was completed in June 2001. There was extensive work exploring alternative payment methodologies using linked Medicare/Medicaid data and Minimum Data Set (MDS) data. Medicare and Medicaid claims data were linked to devise a rate-setting mechanism that will work for plans that enroll a disproportionate share of frail elderly. The State sub-contracted work to the Center for Health Plan Development and Management at the University of Maryland in Baltimore County. ■

97-210 **Data Collection for Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration**

Project Officer: Thomas Theis
Period: November 1996-December 2003
Awardee: Lewin Group
Funding: $7,052,998

Description: This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. The information gathered served three primary functions: 1) baseline and follow-up data for the analyses; 2) clinical information to the participating S/HMO-II sites for care planning; and 3) data for risk-adjustment.

Status: Reports to Congress have been prepared, and are undergoing clearance. The work was done by Mathematica Policy Research under a subcontract. ■

93-078 **Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization Demonstration**

Project Officer: Thomas Theis
Period: September 1993-December 2001
Awardee: University of Minnesota, School of Public Health, Institute for Health Services Research
Funding: $2,251,123

Description: The purpose of the Second Generation Social Health Maintenance Organization (S/HMO II) demonstration is to integrate acute and long-term care services within a capitated managed care system. It was developed to refine the targeting and financing methodologies and the benefit design of the current S/HMO model, which was initiated as a demonstration in 1985. In January 1995, CMS selected six organizations to participate in the (S/HMO II) demonstration. The S/HMO II demonstration features a greater emphasis on geriatric care and a more inclusive case-management system. Another distinguishing characteristic of the project is its risk-adjusted payment methodology that is based on an individual's health status and functioning level. The primary focus of the project's evaluation is to compare beneficiaries enrolled in the demonstration with beneficiaries in a section 1876 HMO program, now the M+C program. This project has been providing technical assistance and support in the development, implementation, and operation of the demonstration. There is only one operating S/HMO II site, which is the Health Plan of Nevada, located in Las Vegas.

Status: The project developed a questionnaire that is being used to determine a beneficiary's capitated payment rate; a series of geriatric protocols is being used to help physicians identify and treat certain health conditions, and a care coordination assessment instrument is being used to assist case managers with care planning. This project has provided additional technical assistance in the operation of this remaining operating site. They are also developing a case study regarding qualitative aspects of the demonstration site. The Health Plan of Nevada began enrolling beneficiaries in the demonstration in November 1996. This site's enrollment at the end of 2001 was over 38,000 members. ■

93-006 **Managing Medical Care for Nursing Home Residents: United HealthCare Corporation, Inc. (EverCare)**

Project Officer: Dennis Nugent
Period: December 1992-December 2001
Awardee: United HealthCare Corporation
Funding: $0

Description: This demonstration studied the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners), who function as primary medical caregivers and case managers. The major goals were to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients are able to be managed safely in nursing homes with expanded services. EverCare received a fixed capitated payment (based on a percentage of the adjusted average per capita cost) for all nursing home residents enrolled and was at full financial risk for the cost of acute-care services for the enrollees. Six demonstration sites participated: Boston, Massachusetts; Baltimore, Maryland; Atlanta, Georgia; Denver, Colorado; Phoenix, Arizona; and Tampa,

Florida. Physician incentive plans are structured to offer a higher reimbursement rate for a nursing home visit and a lower reimbursement rate for services furnished in physicians' offices or in other settings. By increasing the intensity and availability of medical services, EverCare hypothesized that this case-management model would reduce total care costs, improve the quality of care received by participants through better coordination of appropriate acute-care services, and improve the quality of life for, and the level of satisfaction of, enrollees and their families.

Status: CMS is working with EverCare to develop quality-of-care measures and payment systems that reflect special populations. EverCare is a subsidiary of United HealthCare Corporation, Inc. and functioned as the project's operating principal. ■

97-216 **Evaluation of the EverCare Demonstration Program**

Project Officer: John Robst
Period: September 1997-December 2001
Awardee: University of Minnesota
Funding: $1,544,142

Description: For each of the five EverCare sites, two comparison groups were selected: 1) nonparticipating residents in EverCare site nursing homes and 2) residents in nonparticipating nursing homes operating in EverCare demonstration cities.

Status: Site visits have been made to EverCare and non-EverCare facilities in each of the participating sites. A survey of EverCare residents, proxies for residents, and control group nursing home residents has been conducted. Data are currently being analyzed. A final evaluation report was due in late 2001. ■

97-018 **Age Well Option (now referred to as TLC)**

Project Officer: William Clark
Period: May 1997-April 2002
Awardee: Hebrew Rehabilitation Center for the Aged
Funding: $600,000

Description: In this project, community care and educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decision-making, and chronic disease management. The populations studied are individuals living in the Hebrew Rehabilitation Center for the Aged and those living in subsidized housing in the Boston community. Educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decision-making, and chronic disease management.

Status: In progress. ■

84-008 **On Lok's Risk-Based Community Care Organization for Dependent Adults: California Department of Health Services**

Project Officer: Michael Henesch
Period: November 1983-November 2001
Awardee: California, Department of Health Services
Funding: $0

Description: On Lok is a unique model of managed-care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. This is the original model that is the basis of the Program of All-inclusive Care for the Elderly (PACE) demonstration includes, as core services, the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term-care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center, whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to

assume financial risk progressively over 3 years. This is one of the sites, and their State Medicaid agencies, that have been granted waiver approval to provide services under this demonstration.

Status: In response to changes in Title XVIII of the Social Security Act made by the Balanced Budget Act of 1997, PACE is being established as a permanent part of the Medicare program and as a State option under Medicaid. It is expected that the demonstration sites will transition from a demonstration to a permanent entity. ■

84-001 On Lok's Risk-Based Community Care Organization for Dependent Adults: On Lok Senior Health Services

Project Officer: Michael Henesch
Period: November 1983-November 2001
Awardee: On Lok Senior Health Services
Funding: $0

Description: On Lok is a unique model of managed-care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage, and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. This is the original model that is the basis of the Program of All-inclusive Care for the Elderly (PACE) demonstration includes, as core services, the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term-care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years. This is one of the sites and their State Medicaid agencies that have been granted waiver approval to provide services under this demonstration.

Status: In response to changes in Title XVIII of the Social Security Act made by the Balanced Budget Act of 1997, PACE is being established as a permanent part of the Medicare program and as a State option under Medicaid. It is expected that the demonstration sites will transition from a demonstration to a permanent entity. ■

Program of All-Inclusive Care for the Elderly

This demonstration replicates a model of managed-care service delivery for very frail community-dwelling elderly persons developed by On Lok Senior Health Services in San Francisco, California. The On Lok demonstration served as the basis for the development of the Program of All-inclusive Care for the Elderly (PACE) provision under the Balanced Budget Act of 1997 (BBA). It enables States to provide PACE services to Medicaid beneficiaries as a State option. Most of the beneficiaries in this demonstration are dually eligible for Medicare and Medicaid coverage and all are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes, as core services, the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term-care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center, whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider.

Changes in Title XVIII of the Social Security Act made by the BBA established PACE as a permanent part of the Medicare program and as a State Option under Medicaid. It is expected that the demonstration sites will transition from a demonstration to a permanent entity.

94-061 **Program of All-Inclusive Care for the Elderly: California Department of Health Services**

Project Officer: Michael Henesch
Period: May 1994-November 2001
Awardee: California, Department of Health Services
Funding: $0

Description: California is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

95-092 **Program of All-Inclusive Care for the Elderly: California**

Project Officer: Michael Henesch
Period: April 1995-November 2001
Awardee: California, Department of Health Services
Funding: $0

Description: California is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. Aid agencies grant waiver approval to provide services under this demonstration. ■

94-040 **Program of All-Inclusive Care for the Elderly: Sutter Senior Care**

Project Officer: Michael Henesch
Period: May 1994-November 2001
Awardee: Sutter Health System
Funding: $0

Description: Sutter Senior Care is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

95-093 **Program of All-Inclusive Care for the Elderly: Center for Elders' Independence**

Project Officer: Michael Henesch
Period: April 1995-November 2001
Awardee: Coalition of Elders' Independence
Funding: $0

Description: Center for Elders' Independence is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-002 **Program of All-Inclusive Care for the Elderly: AltaMed Senior Buena Care**

Project Officer: Michael Henesch
Period: November 1998-November 2001
Awardee: AltaMed Health Services Corp.
Funding: $0

Description: AltaMed Senior Buena Care is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-217 **Program of All-Inclusive Care for the Elderly: Colorado**

Project Officer: Michael Henesch
Period: October 1991-November 2001
Awardee: Colorado, Department of Health Care Policy and Financing
Funding: $0

Description: Colorado is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. The model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years. This award to the State Medicaid agencies grants waiver approval to provide services under this demonstration. ■

98-218 **Program of All-Inclusive Care for the Elderly: Total Longterm Care, Inc.**

Project Officer: Michael Henesch
Period: October 1991-November 2001
Awardee: Total Longterm Care
Funding: $0

Description: Total Longterm Care, Inc. is one of the sites, and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-008 **Program of All-Inclusive Care for the Elderly: Hopkins Elder Plus**

Project Officer: Michael Henesch
Period: March 1999-November 2001
Awardee: Hopkins Elder Plus
Funding: $0

Description: Hopkins Elder Plus is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-211 **Program of All-Inclusive Care for the Elderly: Massachusetts**

Project Officer: Michael Henesch
Period: June 1986-November 2001
Awardee: Massachusetts, Division of Medical Assistance
Funding: $0

Description: Massachusetts is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-212 **Program of All-Inclusive Care for the Elderly: East Boston Neighborhood Health Center**

Project Officer: Michael Henesch
Period: June 1989-November 2001
Awardee: East Boston Geriatric Services Corp.
Funding: $0

Description: East Boston Neighborhood Health Center is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-003 **Program of All-Inclusive Care for the Elderly: Harbor Health Services, Elder Service Plan**

Project Officer: Michael Henesch
Period: November 1998-November 2001
Awardee: Harbor Health Services, Elder Service Plan
Funding: $0

Description: Harbor Health Services, Elder Service Plan is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-004 **Program of All-Inclusive Care for the Elderly: Cambridge Hospital**

Project Officer: Michael Henesch
Period: December 1998-November 2001
Awardee: Cambridge Hospital Professional Service Corporation
Funding: $0

Description: Cambridge Hospital is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-005 **Program of All-Inclusive Care for the Elderly: Fallon Community Health Plan, Elder Service Plan**

Project Officer: Michael Henesch
Period: December 1998-November 2001
Awardee: Fallon Community Health Plan
Funding: $0

Description: Fallon Community Health Plan, Elder Service Plan is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-129 **Program of All-Inclusive Care for the Elderly: Elder Serve Plan of Mutual Health Care**

Project Officer: Michael Henesch
Period: September 1999-November 2001
Awardee: Elder Serve Plan of Mutual Health Care
Funding: $0

Description: Elder Serve Plan of Mutual Health Care is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-207 **Program of All-Inclusive Care for the Elderly: Michigan**

Project Officer: Michael Henesch
Period: May 1997-November 2001
Awardee: Michigan, Department of Social Services
Funding: $0

Description: Michigan is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-215 **Program of All-Inclusive Care for the Elderly: New York - I**

Project Officer: Michael Henesch
Period: September 1989-November 2001
Awardee: New York, Department of Social Services
Funding: $0

Description: New York is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-205 **Program of All-Inclusive Care for the Elderly: New York - II**

Project Officer: Michael Henesch
Period: May 1990-November 2001
Awardee: New York, Department of Social Services
Funding: $0

Description: New York is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration Medicaid agencies, grants waiver approval to provide services under this demonstration. ■

98-206 **Program of All-Inclusive Care for the Elderly: Independent Living for Seniors via Health**

Project Officer: Michael Henesch
Period: May 1990-November 2001
Awardee: Rochester Memorial
Funding: $0

Description: Rochester Memorial is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-216 **Program of All-Inclusive Care for the Elderly: Beth Abraham Health Services**

Project Officer: Michael Henesch
Period: September 1989-November 2001
Awardee: Beth Abraham
Funding: $0

Description: Beth Abraham Health Services is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-010 **Program of All-Inclusive Care for the Elderly: Loretto Independent Living Services**

Project Officer: Michael Henesch
Period: April 1999-November 2001
Awardee: Loretto Independent Living Services
Funding: $0

Description: Loretto Independent Living Services is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-130 **Program of All-Inclusive Care for the Elderly: Eddy Senior Care**

Project Officer: Michael Henesch
Period: September 1999-November 2001
Awardee: Eddy Senior Care
Funding: $0

Description: Eddy Senior Care is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-006 **Program of All-Inclusive Care for the Elderly: Concordia Care**

Project Officer: Michael Henesch
Period: February 1999-November 2001
Awardee: Concordia Care
Funding: $0

Description: Concordia Care is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-009 **Program of All-Inclusive Care for the Elderly: TriHealth Senior Link**

Project Officer: Michael Henesch
Period: March 1999-November 2001
Awardee: Bethesda Hospital, Inc.
Funding: $0

Description: TriHealth Senior Link is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-213 **Program of All-Inclusive Care for the Elderly: Oregon**

Project Officer: Michael Henesch
Period: June 1989-November 2001
Awardee: Oregon, Department of Human Resources
Funding: $0

Description: Oregon is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

90-024 **Program of All-Inclusive Care for the Elderly: ElderPlace**

Project Officer: Michael Henesch
Period: June 1990-November 2001
Awardee: Sisters of Providence in Oregon, Shared Services Division
Funding: $0

Description: ElderPlace is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-219 **Program of All-Inclusive Care for the Elderly: South Carolina**

Project Officer: Michael Henesch
Period: October 1989-November 2001
Awardee: South Carolina, Department of Health and Human Services
Funding: $0

Description: South Carolina is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-220 **Program of All-Inclusive Care for the Elderly: Richland Memorial Hospital - Palmetto Health Alliance**

Project Officer: Michael Henesch
Period: October 1989-November 2001
Awardee: Richland Memorial Hospital - Palmetto Health Alliance
Funding: $0

Description: Richland Memorial Hospital - Palmetto Health Alliance is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

99-007 **Program of All-Inclusive Care for the Elderly: Hamilton County**

Project Officer: Michael Henesch
Period: January 1999-November 2001
Awardee: Alexian Brothers Community Services
Funding: $0

Description: Hamilton County is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-209 **Program of All-Inclusive Care for the Elderly: Texas**

Project Officer: Michael Henesch
Period: June 1991-November 2001
Awardee: Texas, Health and Human Services Commission
Funding: $0

Description: Texas is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-210 **Program of All-Inclusive Care for the Elderly: Bienvivir Senior Health Services**

Project Officer: Michael Henesch
Period: June 1991-November 2001
Awardee: Bienvivir Senior Health Services
Funding: $0

Description: Bienvivir Senior Health Services is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term-care services are arranged. ■

99-128 **Program of All-Inclusive Care for the Elderly: Providence ElderPlace**

Project Officer: Michael Henesch
Period: September 1999-November 2001
Awardee: Sisters of Providence Health System, Continuum Development and Long Term Care
Funding: $0

Description: Providence ElderPlace is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-221 **Program of All-Inclusive Care for the Elderly: Wisconsin**

Project Officer: Michael Henesch
Period: November 1989-November 2001
Awardee: Wisconsin, Department of Health and Social Services
Funding: $0

Description: Wisconsin is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-222 **Program of All-Inclusive Care for the Elderly: Community Care for the Elderly**

Project Officer: Michael Henesch
Period: November 1989-November 2001
Awardee: Community Care
Funding: $0

Description: Community Care for the Elderly is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

98-265 **Program of All-Inclusive Care for the Elderly: Elder Care Options**

Project Officer: Michael Henesch
Period: March 1998-November 2001
Awardee: Elder Care Options
Funding: $0

Description: Elder Care Options is one of the sites and the State Medicaid agency has been granted waiver approval to provide services under this demonstration. ■

97-016 **Evaluation of the Program of All-Inclusive Care for the Elderly (PACE)**

Project Officer: Frederick Thomas III
Period: April 1997-January 2001
Awardee: Abt Associates
Funding: $1,238,917

Description: This project was a comparison of the Program of All-Inclusive Care for the Elderly (PACE) capitation rates to projected costs in the first year of enrollment. It analyzed cost and savings to the Medicare and Medicaid programs. Savings were defined as the capitated payment rates actually paid to PACE sites less projected medical costs in the absence of PACE. Costs were projected because fee-for-service claims data were not available for PACE enrollees after they entered the program. Conceptually, the projection model assumed that enrollee medical costs would continue at their pre-PACE levels but would increase after enrollment based on the experience of a comparison group for whom Medicare and Medicaid claims were known. The comparison group was comprised of individuals who were considered eligible for PACE, but who declined to enroll. The data used in this study were collected between 1995 and 1997.

Status: The report is available on the CMS Web site at: http://www.CMS.gov/ord/resrpub.htm. ■

01-214 **Evaluation of the Program of All-inclusive Care for the Elderly (PACE) as a Permanent Program and of a For-Profit Demonstration**

Project Officer: Fred Thomas
Period: September 2001-September 2002
Awardee: Mathematica Policy Research
Funding: $319,840

Description: The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that seeks positive outcomes and cost savings by providing a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. The demonstration expanded to 11 sites by 1995 and 25 sites by 1999. The Balanced Budget Act of 1997 (BBA) established PACE as a permanent Medicare program, option under the Medicaid program, and established a demonstration of PACE by for-profit providers. In addition, it required an evaluation of the for-profit PACE demonstration to determine if the costs, quality of service, and access to services are comparable to the permanent PACE program. This project first covers the evaluation of the permanent program in terms of, site attributes, patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data. This project will assess the limitation of, and expand on the foundations laid in the previous evaluations of PACE by predicting costs beyond the first year of enrollment, assessing the impact of higher end-of-life costs and long term nursing home care, and assessing the impact of local treatment practices. Secondly, for the evaluation of the for-profit demonstration, the specific questions from the BBA should be answerable by comparing site attributes, patient characteristics, and utilization data of the permanent PACE providers to the for-profit demonstration providers.

Status: This newly initiated project is in the startup phase. CMS expects the for-profit demonstration to become operational by the winter of 2002. All existing demonstration sites, which are non-profit entities, must convert to permanent program sites in 2002. In 2000,

CMS released the final study of the PACE demonstration. Previous studies released during the mid-1990s found that enrollment in PACE was associated with high patient satisfaction, lower mortality, and lower inpatient and skilled nursing facility utilization. ■

96-056 **Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance**

Project Officer: Mary Wheeler
Period: September 1990-September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $3,203,917

Description: The purpose of this project is to develop a core data set that is the foundation for an outcome-based quality improvement (OBQI) system for the Program of All-Inclusive Care for the Elderly (PACE) program. The OBQI system consists of two phases during which the PACE sites complete the data instrument that contains items for outcome measurement and risk adjustment at specific time intervals. Using the data collected in the first phase, site-level reports can be produced summarizing the outcome measures. By comparing site-level case-mix adjusted outcome reports to other PACE site outcome reports, and to the site's previous outcome reports from earlier time periods, the site, CMS, and the State Medicaid agencies are able to identify areas that require further examination due to inferior (or perhaps superior) outcomes. In the second phase, the sites take a closer look at why and how the specific outcomes are achieved and make recommendations for improvements in the case of poor (or perhaps superior) outcomes.

Status: Significant progress has been made in the development of outcome indicators for PACE. The OBQI contract was modified in October 1999, which expanded the period of performance and increased the level of effort to support the development of a core comprehensive assessment instrument for PACE providers. Although this change in the timeline will delay the OBQI component, the burden of data collection on the PACE sites will be decreased. ■

00-112 **Actuarial Assessment of PACE Enrollment Characteristics in Developing Capitated Payments**

Project Officer: Frederick Thomas III
Period: September 2000-December 2001
Awardee: University of Wisconsin - Madison
Funding: $120,460

Description: This project was an actuarial evaluation and assessment of payment rates for the Program of All-Inclusive Care for the Elderly (PACE). The study assessed potential risk elements, such as the financial risk that PACE organizations incur as a result of their smaller enrollment numbers, biased populations, and higher mortality. Payments for medical services furnished by PACE organizations are fully capitated by Medicare and Medicaid. Because of their unique niche, total reliance on capitated payments (Medicare and Medicaid), lower enrollee levels, and higher mortality rates, PACE organizations may have a higher level of financial risk than Medicare+Choice (M+C) plans.

Status: Studies suggest that PACE enrollees are sicker, frailer, and more costly than the average Medicare beneficiary. ■

01-168 **Pilot Test and Analysis of the Medicare Health Survey for PACE and EverCare**

Project Officer: Ron Lambert
Period: September 2001-July 2002
Awardee: Health Economics Research
Funding: $428,922

Description: The purpose of this project is to determine the feasibility of implementing a variant of the Health Outcome Survey (HOS) for organizations that serve special populations. This project will: 1) administer the Medicare Health Survey for PACE and EverCare (MHSPE) to a sample of the Program of All-Inclusive Care for the Elderly (PACE) and EverCare enrollees; 2) collect and validate MHSPE pilot survey data; and 3) perform the appropriate analysis to measure the impact on response rates of various approaches administered under the pilot survey. Such organizations include PACE and

EverCare, among others. To assess the feasibility of applying HOS to specialty plans, the HOS was administered to PACE and EverCare on a pilot basis in 1999. The response rates to the HOS for these plans were significantly below the response rates for the Medicare+Choice (M+C) program. CMS developed a variant of the HOS for use with frail Medicare beneficiaries enrolled in specialty plans. This survey was intended to serve as a means to compare outcome measures across M+C and specialty plans, and to support further research on payment to specialty plans. The primary goals of the MHSPE were: to improve response rates over the experience of the 1999 HOS and to more accurately describe the health and functional status of the target populations. CMS intends to pilot test the MHSPE on a subset of PACE and EverCare enrollees.

Status: This newly initiated project is in the startup phase. ■

00-085 **Ambulatory Care Sensitive Conditions - II**

Project Officer: Jennifer Harlow
Period: September 2000-March 2002
Awardee: Health Economics Research
Funding: $171,736

Description: The purpose of this task order is to further refine and validate hospital discharge rates for Ambulatory Care Sensitive Conditions (ACSCs) and develop a method for case-mix adjusting the ACSC rates at the Medicare+Choice (M+C) organization level. An ACSC is a hospitalization that was potentially avoidable with the provision of timely and effective ambulatory care. These tasks will be conducted using M+C inpatient encounter data submitted to CMS for the period July 1997 though June 1998 and also fee-for-service (FFS) claims data for the same time frame. The presence of an ACSC provides an indication that an individual may not have been receiving appropriate ambulatory care. The preliminary research using 1 year of M+C encounter data has shown that the rates can be applied at the M+CO level to evaluate the provision of care; however, before the ACSC rates can be used as a measure to evaluate M+CO performance the rates should be further refined and validated for the population over 65 years. Additionally, in order to compare rates of ACSCs at the M+CO level a method for case-mix adjusting rates needs to be developed in order to account for variation in the health status of M+CO enrollees.

Status: The contractor has conducted data analyses and has produced draft reports on the refinement of different ACSC indices and case-mix adjustment. ■

00-063 **Applying the Chronic Illness and Disability Payment System to Medicare Data**

Project Officer: Sarah Thomas
Period: September 2000-September 2001
Awardee: University of California at San Diego
Funding: $197,956

Description: The purpose of this project is to provide technical consulting and analytic services to help CMS evaluate the Chronic Illness and Disability Payment System (CDPS) model as an option for a potential Medicare+Choice payment system. The CDPS model was calibrated using Medicare data, which may involve the need to make adjustments to the model as it currently stands, and will provide CMS with the up-to-date software and recalibration. This project also involves documenting the logic of the model, changes that were made to the model through the analysis, and validation statistics. The model will be tested on groups that include beneficiaries with and without hospitalization, groups defined by spending levels in the base year, and groups defined on the basis of illness.

Status: Software to CMS for three versions of the CDPS Medicare model together with measures of predictive .accuracy was developed. ■

00-086 **Updating the Johns Hopkins University ACG/ADG Risk Adjustment Methods for Medicare Contracting**

Project Officer: Jesse Levy
Period: September 2000-March 2001
Awardee: Johns Hopkins University, School of Hygiene and Public Health
Funding: $272,902

Description: This work allowed CMS to better assess and evaluate The Johns Hopkins University's (JHU) Ambulatory Care Group/Ambulatory Diagnosis Group (ACG/ADG) model as an option for a potential Medicare+Choice payment system. JHU revised, extended and recalibrated the ADG/ACG model using recent Medicare data. They provided CMS with the updated software and a recalibration. Earlier work by JHU for CMS updated the ACG/ADG Risk Adjustment Method for application to Medicare risk contracting. In that project, JHU developed two diagnosis-based risk adjustor models. Work on these alternatives to the then existing demographic-only risk adjustment models was concluded in 1996. In subsequent work, entitled "Applying JHU ACG/ADG Risk Adjustment Methods to Medicare Risk Contracting," JHU further developed their model for Medicare purposes. This concluded in early 2000.

Status: This project is completed. ■

96-211 **Refinements to Medicare Diagnostic Cost Group Risk Adjustment Models**

Project Officer: Melvin Ingber
Period: September 1996-July 2002
Awardee: Health Economics Research
Funding: $845,277

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations has been developed and subsequently improved. Because the Balanced Budget Act of 1997 (BBA) mandated risk adjusters to be used for Medicare+Choice entities in year 2000, this project further updates the models with newer data (1995-1996) and provides better adjustment for factors such as "working aged" and "institutionalized." The updated/new models will also be used to pay plans in the Choices demonstration, if feasible. The diagnostic-cost-group (DCG) family of models is the most mature set of risk adjusters available. Among the DCG models are the Principal Inpatient DCG model, which uses hospital data only, and the hierarchical co-existing conditions model, which uses physician and outpatient information as well. It is a hospital-based model that is required for year 2000 by the BBA. Thereafter, an all-claims model should be phased in to adjust payments optimally.

Status: A final report on the hospital-based model was submitted in 1999. ■

00-087 **Applying the Clinically Detailed Risk Information System for Cost (CD-RISC) to Medicare+Choice Payments**

Project Officer: John Robst
Period: September 2000-November 2001
Awardee: RAND Corporation
Funding: $245,934

Description: This project provided technical consulting and analytic services to assess and evaluate the Clinically Detailed Risk Information System for Cost (CD-RISC) model as an option for a potential Medicare+Choice payment system. The project calibrated the CD-RISC model on Medicare data, which involved the need to make adjustments to the model, and provided CMS with the up-to-date software and calibration. During earlier work funded by CMS, CD-RISC was developed to potentially apply to capitation payments for the under-65 population. This model had not yet been calibrated or tested on Medicare beneficiaries and expenditures. In response to our mandate from the Balanced Budget Act of 1997, CMS implemented a risk adjustment method for Medicare+Choice payments. That method relies on inpatient data only. CMS is considering using a risk adjustment method that relies on data from multiple care settings. This project evaluated the CD-RISC model using data from multiple care settings.

Status: The project is completed. ■

00-019 **Risk Adjustment Implementation for Medicare Demonstrations**

Project Officer: James Hawthorne
Period: September 1999-March 2002
Awardee: Fu Associates
Funding: $68,426

Description: The risk adjuster was applied to the Medicare Choices Demonstration, Department of Defense Subvention Demonstration, Social Health Maintenance Organizations Demonstration I, and Social Health Maintenance Organizations Demonstration II populations. A modification provides

an additional task for the contractor to calculate risk adjuster scores for the treatment and control groups used in the evaluation of the Community Nursing Organization demonstration.

Status: This is a project to provide a technical assistance service for the operation of the above named demonstrations. ■

00-080 **Research on a Screening Tool to Identify Adults with Special Health Care Needs and Compilation of a Compendium of Screening Tools for States and Managed Care Organizations to Use in Identifying Adults and Children with Special Health Care Needs**

Project Officer: Ann Page
Period: September 2000-September 2001
Awardee: Foundation for Accountability
Funding: $233,387

Description: This research project built on prior research in developing and testing screening tools for identifying children with chronic conditions. A compilation of alternative tools and critiques into a single compendium supported the States by disseminating information on the comparative effectiveness of alternative approaches to identifying enrollees with special health care needs.

92-070 **Community Nursing Organization Demonstration: Carle Clinic Association**

Project Officer: Thomas Theis
Period: September 1992-December 2001
Awardee: Carle Clinic Association
Funding: $1,786,629

Description: This was one of the four Community Nursing Organization (CNO) Demonstrations. The two fundamental elements of the CNO are capitated payment and nurse case management. These elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute-care services. Legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. The selected sites represent a mix of urban and rural sites and different types of health providers, including a home health agency, a hospital-based system, and a large multi-specialty clinic.

Status: All four CNO demonstration sites underwent a 1-year development period and began a 3-year operational period in January 1994. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 1999. The Balanced Budget Refinement Act of 1999 extended the demonstration until December 2001 and included a budget neutrality requirement. The Benefits Improvement and Protection Act of 2000 removed the budget neutrality requirement of BBRA but reduced projected rates by 10 percent for three CNO sites and 15 percent for the New York site. It also included actuarial adjustments. Two sites ceased to participate in 2000; two sites continued operations through 2001. ■

92-073 **Community Nursing Organization Demonstration: Visiting Nurse Service of New York**

Project Officer: Thomas Theis
Period: September 1992-December 2001
Awardee: Visiting Nurse Service of New York
Funding: $945,282

Description: This project was one of the four Community Nursing Organization (CNO) Demonstration sites. The two fundamental elements of this demonstration were capitated payment and nurse case management. These elements were designed to promote timely and appropriate use of community health services and to reduce the use of costly acute-care services. The demonstrations were mandated by legislation which also mandated a CNO service package that included home health care, durable medical equipment, and certain ambulatory care services. The selected sites represented a mix of urban and rural sites and different types of health providers, including a home health agency, a hospital-based system, and a large multi-specialty clinic.

Status: All four CNO demonstration sites underwent a 1-year development period and began a 3-year operational period in January 1994. The Balanced Budget Act of 1997 extended the demonstration period through December 1999. The Balanced Budget

Refinement Act of 1999 extended the Demonstration until December 2001 and included a budget neutrality requirement. The Benefits Improvement and Protection Act of 2000 removed the budget neutrality requirement of BBRA but reduced projected rates by 10 percent for three CNO sites and 15 percent for the New York site. It also included actuarial adjustments. Two sites ceased to participate in 2000, two sites continued operations through 2001. ■

00-064 **Evaluation of Community Nursing Organization (CNO) Demonstrations, Phase II**

Project Officer: Victor McVicker
Period: September 2000-September 2002
Awardee: Abt Associates
Funding: $246,367

Description: This project evaluates the design and implementation of Phase II of The Community Nursing Organization (CNO) Demonstration. The demonstration has been extended several times, most recently by the Balanced Budget Refinement Act of 1999, which extended the demonstration through December 2001 and mandated an additional evaluation of the demonstration that is due to Congress no later than July 2001. The Phase I evaluation covers the initial period of operation of the demonstration. The Phase II evaluation provides for longer term follow-up of early participants and also includes an assessment of the effects of the CNO intervention on later participants whose data were not available for Phase I evaluation. The Phase II evaluation requires the use of hierarchical-coexisting-conditions risk adjusted estimates of Medicare expenditures for Medicare beneficiaries who participated in the demonstration as well as for a new comparison group. The calculation of the risk adjuster scores is being contracted separately and the resulting data will be made available to this Phase II evaluation.

Status: The Benefits Improvement and Protection Act of 2000 requires a preliminary report due no later than July 2001 and a final report to Congress no later than July 2002. The preliminary report to Congress is being reviewed. ■

00-088 **Additional Analyses of Community Nursing Organization (CNO) Demonstration Data**

Project Officer: Victor McVicker
Period: September 2000-December 2001
Awardee: Abt Associates
Funding: $204,637

Description: This project performed additional analysis of the Community Nursing Organization demonstration claims data. The additional analysis was requested by Congress because a 1998 interim report by the evaluation contractor differed from the final evaluation report. The analysis is to identify the cause or causes of the changes in order to fully understand the differences between the interim and final report and answer Congress' questions and concerns.

Status: A final report was submitted on March 2001. ■

MUNICIPAL HEALTH SERVICES PROGRAM

The project is part of the Municipal Health Services Program (MHSP), a collaborative effort of four major cities, the United States Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

97-201 **Municipal Health Services Program: Baltimore**

Project Officer: Ronald Deacon
Period: June 1978-December 2004
Awardee: City of Baltimore
Funding: $0

97-204 **Municipal Health Services Program: Cincinnati**

Project Officer: Ronald Deacon
Period: June 1978-December 2004
Awardee: Center for Health Policy Research, University of Colorado
Funding: $0

97-203 **Municipal Health Services Program: Milwaukee**

Project Officer: Ronald Deacon
Period: June 1978-December 2004
Awardee: City of Milwaukee
Funding: $0

97-202 **Municipal Health Services Program: San Jose**

Project Officer: Ronald Deacon
Period: June 1978-December 2004
Awardee: City of San Jose
Funding: $0